

U.S. NAVY MEDICAL DEPARTMENT ORAL HISTORY PROGRAM

ORAL HISTORY WITH  
CAPT (ret.) HELMER WALTER SCOTT HUSEBY, MC, USN

CONDUCTED BY  
CAPT (ret.) THOMAS SNYDER, MC, USN

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OFFICE OF MEDICAL HISTORY  
BUREAU OF MEDICINE AND SURGERY  
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**This is an interview with Doctor Helmer Walter Scott Huseby. The date is 19 November 2014 and it's 1400 hours.**

**Q:** Dr. Huseby's going to talk to us about his experiences in the Navy, but first I think we should start with the introductory material like where you were born and something about your childhood and your early education.

**A:** I was born in the town of Cloquet, Minnesota and my father was a physician near by the town of Floodwood. He went into practice in 1927 and joined another physician in Cloquet. They started another practice in Floodwood, which was a little Finnish town in Minnesota about 30 miles away.

**Q:** So what part of Minnesota is this?

**A:** Cloquet is 20 miles west of Duluth, and Floodwood is about 40 miles west of Duluth.

**Q:** So that's pretty far north.

**A:** My dad had a family practice. My mother was a nurse and we had a treatment room in the house. The town was about 600 people. They would do in home deliveries in town and out on the farms. He would take care of all the injuries in the treatment room at our home including taking out tonsils and with my mother giving ether anesthesia.

Q: And you remember this, of course?

A: No, I was born in 1929 and was less than four years old during this time. My father developed pneumococcal pneumonia in 1934 when he was 34 years old and passed away. We moved to Duluth where my mother had grown up. My grandmother came to live with my sister and me when my mother went to the University of Minnesota to become a surgical nurse. Eventually, she became a nurse anesthetist in Duluth.

Q: So you went to public schools in Duluth?

A: We then moved to my grandmother's house out in the country where we attended a country grade school. I went to public schools in Duluth. The University of Minnesota started a new campus up in Duluth in 1947. I graduated from high school in 1948 and started the University of Minnesota in Duluth. While an undergraduate I majored in chemistry and minored in zoology and mathematics during my four years in pre-med.

I started medical school in 1952 at the University of Minnesota, Minneapolis and graduated in 1956. My internship was at Anchor Hospital in St. Paul, Minnesota.

Q: Was that an academic program or was it just free standing?

A: It was the city/county hospital associated with the University of Minnesota; there were residents on-staff from the University. Following my internship I entered active duty with the U.S. Navy and went directly to sub school at New London, Connecticut.

Q: So after your internship were you recruited or you just decided you wanted to go to the Navy and see the world?

A: I volunteered. Actually, I signed up for the Berry Plan.<sup>1</sup>

Q: Alright, so the Berry Plan was in place then?

A: With the Berry Plan, they would defer Active Duty until you finished your residency training. Then you would go on Active Duty.

Q: What year was this?

A: This was in 1957.

Q: So, at that point you were at risk for being drafted?

A: I might have been.

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<sup>1</sup> Berry Plan—Armed Forces Physicians Appointment and Residency Consideration Program (or Berry Plan). Conceived in 1954 by Assistant Secretary of Defense for Health Affairs Frank B. Berry (1892-1976), the Berry Plan allowed for physicians to be deferred from military service while pursuing training in medical specialties that they would use in their two-year military commitment. The adoption of the all-volunteer military force in 1973 marked the end of the Berry Plan.

Q: So you would enroll in the Berry Plan in order to finish your training?

A: If I wanted to take a residency I would be deferred for the length of the residency. I decided not to take a residency at that time and went directly into the Navy. Actually, I was assigned to the Navy by the Berry Plan.

Q: Okay, because you opted not to do a residency? The Berry Plan system said you're going to go to the Navy?

A: The Berry Plan system assigned me to the Navy. I was very fortunate that I was assigned to the Navy.

Q: And they assigned you to the sub school, or did you have a choice?

A: No, I asked to go to sub school. I wanted to become a Submarine and Diving Medical Officer. That was approximately three months at New London followed by three months at the Navy deep sea diving school in Washington, D.C.

Q: What did you learn there? What was your training there?

A: Training at submarine school there was to learn how about the diesel submarines operating mechanics, and how to take command of a submarine. They then tested us in Long Island

Sound at the end of the course, diving and surfacing the diesel submarine.

Q: So this was the same training that the line officers had?

A: The first six weeks was exactly the same. We separated from the line officers at sub school and went on to the Navy Deep Sea Diving School in Washington, DC.

Q: And that was at New London also?

A: No, that was at Washington D.C. The Navy had the deep-sea diving school at the Navy Gun Factory on the Anacostia River in Washington, D.C. We spent three months at the deep-sea diving school. Following the six months of submarine and diving medicine, I was assigned to the Deep Sea Diving School in Washington, DC.

Q: So what year was that?

A: That was 1957. At the deep-sea diving school we were associated with the experimental diving unit; the two units in the same building. At the experimental diving unit we tested the diving tables. My project during that two years was to design and test the Carbon Dioxide absorber on the closed-circuit underwater breathing apparatus, making certain that it functioned. It became operational in 1960.

Q: So this was the first underwater re-circulated breathing?

A: Yes, the re-circulating breathing underwater self-contained diving unit was called the MARK 5.

Q: So you did some initial work on that? You did the CO2 absorber?

A: I worked on the CO2 absorber to make sure that it operated properly. My two years in Washington D.C. ended at the end of 1959. I had applied for an orthopedic residency in the Navy, and was assigned to the orthopedic residency training program at the U.S. Naval Hospital in Chelsea, Massachusetts, near Boston. My adult orthopedics was three years at the U.S. Naval Hospital at Chelsea. The fourth year of orthopedics was children's orthopedics, which was at the Riley Children's Hospital, University of Indiana Medical School in Indianapolis.

Q: Now, at Chelsea, since you're near Boston, did you have opportunities to interact with the academic programs in Boston?

A: We had an association with the Massachusetts General Hospital. We had two months of rotation on the fracture service at the Massachusetts General Hospital.

Q: Did you wear a uniform when you were there?

A: Yes, I did. And we would attend rounds at the Boston Children's Hospital every week, and weekly orthopedic rounds at Massachusetts General Hospital. Boston was one of the centers of orthopedics in the country at that time, and probably still is.

Q: So you went to Indianapolis, and that's because the Navy didn't have pediatrics in their program?

A: The Navy didn't have a children's orthopedic program at the time, so all the pediatric programs were one-year civilian training. For orthopedic training at that time, you paid back one year for every year of residency training in the Navy. For one year of civilian orthopedics, we paid back two years. I had an obligation of five years following my training, and that again was fortunate.

Q: Okay, you'll expand on that?

A: My total of 13 years active duty was absolutely outstanding, academically as well as the experience I gained.

Q: So, after your residency-well, do you have any particular recollections from your residency, either medical or social?



A: I enjoyed my time in Boston. I grew up in the north country, so the cold weather was exactly what I liked. I lived out in the country, north of Boston. We were able to rent a place in Topsfield, Massachusetts about 20 miles north of Boston with 13 acres.

Q: And you commuted into town by car?

A: I commuted back and forth by driving, yes. So, from the University of Indiana in Indianapolis I transferred out to the U. S. Naval Hospital, Oakland. My Chief of Orthopedics in Chelsea was Dana Goldthwaite<sup>2</sup>; he had transferred out to Naval Hospital, Oakland during the year I was at Indianapolis. He was my chief again at U.S. Naval Hospital, Oakland.

Q: You think he had a role in getting you out to Oakland, or was that strictly blind luck?

A: I wanted to come out to the Naval Hospital, Oakland. I don't know whether he had any influence through the Bureau or not, I don't know.

Q: So now you went on active duty after the Korean War?

A: Yes, in July '57.

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<sup>2</sup> Dana Goldthwaite (1914-2000).

Q: And when you came out to Oakland, Vietnam was just beginning to ramp up.

A: Vietnam was still pretty quiet; they were under the Advisor Program.<sup>3</sup>

Q: And you came out to Oakland because you wanted to come to California?

A: I wanted to come out to California. I was assigned to the U.S. Naval Hospital, Oakland. There were two staff captains on the orthopedic service-Dana Goldthwaite and Captain Frank Gulbranson. Captain Gulbranson greeted me and said, "You are now on the augmentee list for the Marine Corps."

Q: Meaning?

A: Apparently they had established an augmentee list for orthopedic surgeons, general surgeons and anesthesiologists sometime in 1964 or earlier. I don't know when, CAPT Gulbranson became an augmentee. When I arrived, I became the augmentee.

Q: The augmentee, what was that?

A: I was on the "list as an augmentee" for the Marine Corps as an orthopedic surgeon. I had no idea what it meant or what

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<sup>3</sup> From 1955 to 1965, United States military advisors served in South Vietnam to train and assist South Vietnamese military personnel in actions against the North Vietnam People's Army.

it was going to amount to. So, I went on the augmentee list for the Marine Corps from the Naval Hospital, Oakland, as the orthopedic surgeon which remained that way until May of 1965.

Q: So in '64 you arrived for a year, basically? You practiced orthopedic surgery?

A: I did general orthopedics. I was the staff orthopedist for the dependant ward. A resident and myself were assigned to the dependant ward.

Q: So you had a variety of orthopedic practice there, kids with broken arms?

A: It was general orthopedics and children's orthopedics. We had orthopedic clinics. It was interesting during that time that Admiral Nimitz was one of our patients. Admiral Nimitz was also a patient on the neurosurgical service because he had a back problem.

Q: Did you ever interact with the Admiral yourself, personally?

A: I didn't. CAPT Dana Goldthwaite, chief of the department, took care of the Admiral. I would see the Admiral in the clinic, but I didn't take care of him.

Q: Your rank then was what?

A: I was lieutenant commander by that time. In March of 1965, the Marines went into Da Nang, Vietnam, to establish security for the airfield, which was operated by the Air Force. Basically they just went in to protect the airfield. That's the time when things started ramping up in Vietnam. The Collecting Clearing Company in Da Nang established a field hospital there.

Q: So the Collecting Clearing Company would be how many people?

A: It's a company; it's about 100. They basically had one surgical team,<sup>4</sup> a group of general medical officers and Corpsmen to run the Collecting Clearing Company, but they converted to a field hospital almost immediately.

Q: Now, a field hospital would be tents?

A: They had some surgical equipment, they just ramped up their equipment so that they could surgically take care of casualties, not just resuscitate and evacuate. They actually did the definitive surgery for all casualties that they had; that was the function of the field hospital.

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<sup>4</sup> General surgeon, orthopedic surgeon, and an anesthesiologist.

They also established a field hospital at Hue, Phu Bai, north of Da Nang, the battalion headquarters at the time when this was all occurring in March, April, and May of '65 was up in Okinawa...

Q: This is the Marine Corps?

A: Battalion Headquarters for the Third Marine Division. The Third Marine Division was the Marine Division in Vietnam in I Corps. On the 7<sup>th</sup> of May, 1965, they had an amphibious landing of Marines at Chu Lai. Chu Lai was a base 60 miles south of Da Nang, which to develop an expeditionary airfield. This was determined by General Victor Krulak.<sup>5</sup> They had previously chosen this location, I don't know how long. The landing at Chu Lai took place on the 7<sup>th</sup> of May 1965 and on the 7<sup>th</sup> of May 1965 I received my orders to join the Marines on TAD status. I don't think they really had established exactly to what extent they were going to go establish troops in Vietnam. The initial wave of surgeons and Corpsmen all went over on Temporary Additional Duty.

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<sup>5</sup> Lt. Gen. Victor Krulak (1913-2008) served as the Commanding General, Fleet Marine Force, Pacific. From 1964 to 1968, Krulak was responsible for all Marine Units in the Pacific, including Vietnam. According to some sources, the Chu Lai base (established in May 1965) was named after Krulak's "Chinese name." Chu Lai purportedly means "Krulak" in Mandarin Chinese." Source: Coram, Robert. *Brute: The Life of Victor Krulak, U.S. Marine*. NY: Little, Brown and Company, 2010.

Q: Now, when the Marines did their landing, was this an opposed landing or they just came ashore and set up their base?

A: They didn't know if it was going to be opposed or not. It turned out not to be opposed. They established a Collecting Clearing Company on the beach at Chu Lai. I received my orders on the 7<sup>th</sup> of May 1965, the day they landed, and deployed four days later. The augmentees, medical officers and Corpsmen joined up in Okinawa.

Q: So it was you, other doctors, Corpsmen?

A: Other augmentees to the Marine Corps. We all had our orders and we ended up in Okinawa with the Third Marine Division. There were two orthopedists—Steve James from Pendleton and myself. There were at least three general surgeons; two of them I trained with at Chelsea, and the third general surgeon I did not know, and the majority of the remaining augmentees were Corpsmen. We had a short orientation in Okinawa.

Q: What was the nature of the orientation?

A: We received our field uniforms. We were all issued a semi-automatic .45 pistol. They trucked us out to the pistol range at Camp Hanson in Okinawa to fire our .45's. I

already had experience with a .45 at submarine school in New London.

Steve James was assigned the Collecting and Clearing Company at Hue, Phu Bai. They already had an orthopedist at the Clearing Company in Da Nang. He probably came in, in March, when the Marines established their base there. I was assigned to Chu Lai. Phu Bai was known as "Fort Apache." In Chu Lai the Marines had gone ashore on May 7, 1965. The medical battalion did not know much about Chu Lai. I was assigned to the Collecting Clearing Company at Chu Lai.

Q: And that would be along with the general surgeon, general practitioners?

A: I believe they came from Camp Pendleton, California. There was an anesthesiologist, and I believe two general surgeons along with Corpsmen and the Medical Service Corps officer LT Dave Tharpe. They established a Collecting Clearing Company on the beach. When I left Okinawa, they told me I was going to be the CO of the future field hospital at Chu Lai.

Q: And your rank at this point?

A: I was Lieutenant Commander. I was to take the Collecting Clearing Company and transition it into a field hospital. Those were my instructions, period.

Q: And here's the manual?

A: No manual. So, we left Okinawa...

Q: Were you the most senior guy in that outfit at that point?

A: I was probably the most senior guy. I had two and a half years in submarine diving medicine, so I had about that much time more than the others that were in that group.

Q: No women, of course?

A: No, all Corpsmen. So, we left Okinawa. Jim McHale and Hank Baer were the general surgeons that I had trained with at Chelsea. They were two of the three general surgeons at Okinawa when I got here. The third general surgeon was assigned to Da Nang, I suspect that Jim McHale decided to go to Chu Lai with me because we all knew each other. I can't be certain. Hank Baer was later transferred to Chu Lai.

So we left Okinawa in a C130, and our first stop was Hue Phu Bai, a deserted airfield north of Da Nang with a solitary machine gun on top of a building; that was it. We



off-loaded some of the Corpsmen, and Steve James, who was the orthopedist assigned to Phu Bai, and then we took off and went to Da Nang. We got to Da Nang and we were all transported to their field hospital, which was C-MED. The one at Phu Bai was A-MED. And Chu Lai was B-MED.

They took us to the field hospital at Da Nang so I could at least see what they had done and they were in tents with the OR, and all of their other functions were under tents. There were no permanent buildings. They had a cold water box, a bath, that they would use for heat exhaustion. I was impressed that the Marines were getting so hot and their temperatures were so high when they came in as casualties that they'd put them in the cold water to cool them off. I didn't have to do that at Chu Lai, but they had to do that up at Da Nang. I think the humidity was higher inland than on the beach.

Q: Where the humidity was high.

A: At least I could see what they had done. The next day we took off in a CH-34<sup>6</sup> helicopters and went down to Chu Lai. We landed in rice paddies down at Chu Lai.

Q: Now this was on the beach?

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<sup>6</sup> CH-34 Sikorsky piston-engine military helicopter.

A: Chu Lai is on the beach. We landed in the rice paddies inland with the other CH-34's. That was the extent of our air support at Chu Lai. At Chu Lai they had gone in with two Marine Battalions and a battalion of Seabees. The Seabees were to build the expeditionary airfield that they wanted to establish. When I arrived at Chu Lai, they had put the Collecting Clearing Company on the beach with the Fleet Logistics Support Unit (FLSU), the engineers and the other support units. Basically at Chu Lai everything was on the beach or a few hundred yards inland where they were going to establish the airstrip. They were constructing this airstrip on the sand.

Q: So when you go there, were there any medical people on the ground when you got there?

A: There was the anesthesiologist.

Q: That's right, the Collecting and Clearing Company came in with the landing force.

A: They came in with the landing force. There was the anesthesiologist, two general surgeons, three general medical officers, dental officers, and the Corpsmen. The Corpsmen were X-ray technicians, laboratory technicians, OR technicians. They had put up an OR tent. The Strongbacks

are a plywood floor with a 2x4 frame and tents over the frames. Portable operating table and operating room lights were inside the tent. We had a gasoline powered sterilizer in the sand at the back of the Collecting Clearing Company. So I had one set of operating room instruments, a gasoline powered sterilizer, portable operating room lights and the field operation table.

Q: Now, the gasoline powered sterilizer boiled water?

A: I think it boiled the water and created the steam for sterilizing instruments.

Q: That was all. You had one set of OR instruments, a sterilizer, one operating room table, and...

A: They put the sterilizer out in the sand in the back of the Collecting Clearing Company in case it burned up. It wasn't the safest apparatus. Every time they wanted to sterilize instruments they'd have to go out and fire it up.

Q: So, were they actually doing surgery regularly when you arrived?

A: They were already taking casualties by the time I got there, so they were operating, and they were able to handle the number of casualties that they were taking because they were coming in one or two or three at a time. They were

managing. I took a look at the situation and I figured, "I've got 4,000 Marines now and 1,000 Seabees, and how am I going to take care of them?" There was an Army Field Hospital in Nha Trang. Nha Trang was halfway down the coast of Vietnam between Da Nang and Saigon. The Army had established a medical unit down there to take care of the advisors. The first thing I did was send a second class Corpsman on the next flight that went down the coast to Nha Trang and told him to bring back a set of operating room instruments so then we'd have two sets instead of one. When you take casualties, you have to keep re-sterilizing which takes time. About that time I think we were establishing a second operating tent. The next thing was to figure out where am I going to get more instruments? Our medical supply line was almost non-existent. I had no contact with Okinawa and had very little communication with Da Nang. The telephone communication had to go through two or three operators before you ever got to your destination and sometimes you never made it.

Q: These are Navy operators?

A: Communication went through the Marine Corps. And needless to say we didn't have very much communication with anybody. We were relatively medically isolated.

Q: On the frontier.

A: So, I thought, well, where am I going to get more instruments. I wrote a letter back to my orthopedic chief of service at the Naval Hospital at Oakland. I knew they had more than enough surgical instruments. This was my idea. I was not following protocol. I had known CAPT Goldthwaite for four years by that time; I gave him a list of instruments I needed.

Q: Was this for you and the general surgeons?

A: Yes, this was our unit. So, I gave him a list of instruments, list of antibiotics, and a list of medications for anesthesia. Well, within about a week I had what I wanted. And it worked so well I wrote to him again. I gave him another list of instruments, medications I needed, and figured this would complete our mission; we could do what we had to do if I could get all of this together, and he sent it to me. I think it came through the battalion headquarters, which had moved to Da Nang, because I got a phone call asking me what I was doing. By that time it didn't make any difference, I had what I needed.

It was interesting, about two or three months later, I put a request in for 25 blood pressure cuffs through the

regular chain of command because it was the only monitoring device we had. Anesthesia had their anesthesia machine with their monitors. Basically, we had to take blood pressures and clinically evaluate the casualties to decide how much trouble they were having and then carry out the resuscitation efforts. I received a phone call turning down the request. Had I tried to get the instruments I needed through channels it would probably have failed.

Q: Your request for 25 blood pressure cuffs was denied?

A: Yes. I think eventually we got some, but it was just an example of how efficient the supply system was at that juncture. In reading the book *Navy Medicine in Vietnam*<sup>7</sup> by Jan Herman book-I think it was mentioned there that they were having supply problems early on. The Marines hadn't had any conflicts to speak of since the Korean War, so these supply chains hadn't been established with any efficiency.

Q: Yes, the infrastructure simply wasn't there.

A: So, the unique part of all this was that we established a field hospital on our own.

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<sup>7</sup> *Navy Medicine in Vietnam: Oral Histories from Dien Bien Phu to the Fall of Saigon* (McFarland Press: Jefferson, NC, 2009).

Q: Literally yes. No prepositioned stuff. I mean, where did the tentage come from? Did it come with the Marines?

A: Yes. It came with the Collecting Clearing Company.

Q: But the idea of expanding it into a field hospital, I mean, basically your writing the book as you're going along.

A: Yes. Having had orthopedic training in the Navy was advantageous. Phu Bai might have had the same problem, I don't know. The base at Chu Lai ended up as a very large complex. The airfield ended up as the largest airfield in Vietnam when they finished the secondary airstrip, and I think it still is the longest airstrip in Vietnam.

Q: Now again, what was the time period we're talking?

A: This time period was May and June of '65.

Q: At this point, what kind of interaction were you having with the Army? You mentioned that you'd sent a Corpsman down to the Army to pick up an OR set. What other interactions, or what kind of interactions did you have with the Army medical establishment at this time or maybe looking forward?

A: We really didn't establish any communication with them. We were at I Corps and they were at II Corps south of us, not

too far south of us, but we didn't have any communication directly with them. The division probably did, but we didn't.

Q: No medical interactions?

A: No, we had no medical interaction. During this time our blood supply was through Japan and the blood we were getting was in insufficient quantity and it was generally about three weeks old when we got it. So, because of the lack of quantity we began drawing blood off the Seabees when casualties came in, in order to supplement our supply.

Q: So you would type the patients when they would come in. The potential donors, the Seabees, already knew what their blood types were right?

A: Yes. We would contact the Seabees to come in and donate blood when we started getting casualties, then we would draw and cross-match blood from the patients. We used type-specific blood or O-positive blood.

Q: And O-negative for sure.

A: Yes.

Q: So you had Corpsmen who were trained to do this? Or did you have to call somebody in?



- A: We had Corpsmen who were laboratory technicians and Corpsmen who were OR technicians.
- Q: I mean, you didn't have a blood bank at this point. There was no established blood bank.
- A: Right, we would depend upon the supply from Japan. Then we decided to establish a blood bank with 100 units.
- Q: Interesting, and how did you decide on a number? Was it based on historical usage?
- A: After a couple weeks experience we decided we needed a 100 unit supply. So we established the blood bank with 100 units.
- Q: Where did you get the reefer?
- A: We got the reefer from the Marines. They had reefers for food, temperature controlled, so we used one of those. One night the thermostat went haywire on the reefer for the blood bank and it froze 100 units, so we redrew another 100 units.
- Q: So, where did you get the collecting gear, the sets--was it glass bottles or plastic bottles?

A: We had the equipment to draw blood. That came with the Collecting Clearing Company and we already had access to that supply.

Q: Was it plastic bags?

A: Yes. It was stored in plastic bags.

Q: And the anticoagulants and stuff, that came with it?

A: It came with it. After about two months the Marines decided that we needed to get off the beach. They picked out a place, a general location about two miles up the beach on higher ground, so didn't have the sand to contend with. One of the Marine majors from the supply unit, a driver, and myself made the recon. The major rode shotgun with the driver, we went up the beach and picked out our new location. We were on a bluff above the water with the beach down in front of us. They assigned us a very nice piece of real estate.

Q: And would there be associated with that a landing area for helicopters and stuff like that?

A: We built a landing pad for helicopters with the same matting used for their expeditionary airfield. It was laid down in sections, and was large enough for two helicopters. It was on the buff above the water. Our hospital was up

behind that. I didn't want to put the landing pad right in the middle of the hospital because there was just too much sand and dirt when the helicopters came in. They built us a bunker manned by the Marines at night, with a squad of Marines out in front of us.

Q: Out in front meaning seaward or landward?

A: We had the ocean on one side, and had real estate on three sides. We were up there for about three or four weeks by ourselves.

Q: You were operating? You were running your hospital?

A: We had established, in our new location, two operating rooms, these were wooden frames covered with plywood, and then the tents put over that to make it waterproof. Basically, we had enclosed operating rooms with window type air conditioners, about four air conditioners per operating room.

Q: The Seabees did this for you?

A: And the Marine engineering company. Tents were used for holding wards in front of the operating rooms.

Q: In front meaning?

A: Down towards the beach, just in front of the operating rooms. We had a large triage tent with about ten stretchers between the helicopter pad and the ORs, also, we had an X-ray unit and a laboratory.

Q: Basic labs? CBCs, basic chemistries?

A: Basic lab and basic pharmacy. During all of this about 50% of our patients were combat casualties, and 50% were medical casualties.

Q: And what kind of medical issues were you seeing?

A: We had virus infections and parasites.

Q: Malaria?

A: Occasional malaria. If they came from farther inland they'd pick up malaria; on the beach they didn't pick it up. And then, of course, we had a number of Marines who would decompensate mentally, we'd have to evacuate them. We were eventually assigned a psychiatrist. He was wonderful. I asked him when he got there what he needed and he said, "I need a tent." He would take these Marines who had decompensated and he would get them back on the front line. He'd get them turned around, a great majority of them. In August, which would have been the third month we were at Chu Lai, Operation Star Light took place. We were already

in our new location by that time. We had two operating rooms, but usually only had one anesthesiologist.

Q: And nobody else to do anesthesia? No nurse anesthetist?

A: We didn't have any anybody else who could do anesthesia at the time. Operation Star Light was the first major conflict in Vietnam. It involved a significant number of Marines. We had 2,000 Vietcong which had established themselves in the villages ten miles south of Chu Lai. They had tunneled and barricaded the villages. When the Marines found out about it they came up with a plan in 48 hours to resolve the problem.

Q: How'd they find out about it?

A: They found out about it through a defector from the Vietcong. They also had some idea that something was happening during their own reconnaissance. They put the two things together and decided they had to go do something. The Vietcong were managed by Vietnamese who had been at Dien Bien Phu with the siege of the French, so they had experience. The Marines made a day break amphibious type assault. They went out to sea with their landing crafts at night and came in over the beach the next morning. Several more companies went down by helicopter landing on the west

side of the village. A blocking force traveled down from Chu Lai overnight from the north side of the villages, they trapped the Vietcong. The Marines took about 250 casualties on the first day of the operation. They lost 52 Marines, 130 casualties were evacuated to our field hospital on day one. The *Iwo Jima* came in from the Philippines later that afternoon on the first day airlifting a company of Marines into the conflict. They started taking casualties back to their ship at the same time. My mathematics tells me that they took about 70 casualties and we took 130.

Q: And none of them went south to Da Nang or anything like that?

A: Not at that point. All casualties came into the field hospital at Chu Lai and to the *Iwo Jima*. The *Iwo Jima* had one surgical team, and we had one functional surgical team. We found early on that morning we couldn't handle all the casualties. We resuscitated the casualties that morning on day one as they came in and started evacuating by helicopter to Da Nang.

Q: Now, by resuscitation, what would be involved in resuscitation?

A: At that time we would reinforce their battle dressings.

Q: To control bleeding, basically?

A: Yes, adding more compression that was needed to control bleeding, I would start blood transfusions to replace blood loss and evacuate the casualties to Da Nang by helicopter with two and three units of blood a piece.

Q: So they had the blood flowing, basically, as they...

A: They were all evacuated to Da Nang, first by helicopter and then by combination helicopter and C-123<sup>8</sup> or C-130 from the airstrip. Evacuating by helicopter was the most efficient because we could send them directly to C-Med, the Da Nang hospital from our own field hospital. If we evacuated by C-123 or C-130,<sup>9</sup> they had to be taken by field ambulance down to the airstrip, which was a couple miles away, then unloaded onto the C-130 and then offloaded in Da Nang and taken to their field hospital; that takes a number of hours to accomplish. By helicopter the trip was about 30 minutes for takeoff to landing.

Q: So did you have to detach Corpsmen to go with these guys as they were being transported, or who went with them?

A: Corpsmen travelled with them to the airfield with other Corpsmen on the evacuation planes.

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<sup>8</sup> Fairchild C-123 is an American military transport aircraft designed by Chase Aircraft.

<sup>9</sup> Lockheed C-130 Hercules is a four-engine turboprop military transport aircraft.

Q: And they were the guys who would be managing the blood?

A: They would be managing the casualties. The trip to Da Nang wasn't very long, it was 60 miles away. It was just getting to the airfield and getting them to the hospital in Da Nang which was time consuming. There were at least two surgical teams and maybe three in Da Nang. Da Nang found out early on day one they couldn't handle all the evacuated casualties that came into them. They had to re-triage and send remaining casualties by C-130 to the Philippine Island Clark Air Force Base. That was 800 miles across the South China Sea. That was several hours more. I think the casualties we evacuated from Chu Lai probably didn't get to Clark Air Force Base for 18 or 24 hours before they received their primary surgical treatments.

Q: These are the guys that you could stabilize and ship, basically?

A: These are the guys we could stabilize and evacuate. We kept the casualties that couldn't survive travel any further than our field hospital at Chu Lai, we took care of those. When I was triaging casualties at Chu Lai that day I know we lost two of the combat casualties that came in; they were mortally wounded when they got to us and couldn't be resuscitated. They passed on within a matter of five or ten



minutes. There were probably 8-10 surgically treated casualties at Chu Lai on day one, two did not survive in spite of surgical treatment.

Q: And they could be arriving by helicopter?

A: They all came in by helicopter CH-34s or Huey. They used anything they could for MEDEVACs, whatever helicopter they could get the casualty into.

Q: That means the casualties could conceivably arrive at your place how soon after their injuries?

A: They could be arriving within 20 to 30 minutes from the time they were wounded. If they had casualties the helicopters were down picking them up as soon as they could.

The pilot of one Army MEDEVAC helicopter during Operation Starlite<sup>10</sup> was killed during his MEDEVAC. Two other helicopter pilots had to take their helicopters back to Chu Lai one twice and the other three times to get replacements when they were shot up; it was a intense

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<sup>10</sup> Operation Starlite (August 18-24, 1965) was the first major offensive conducted by U.S. forces in Vietnam.

conflict. They had two Medal of Honor recipients out of Starlite on day one.<sup>11</sup>

Q: So let's go back and talk a little bit about the overall, sort of, philosophy about managing the casualties. So, resuscitation meant blood replacement, volume replacement. I mean, was there sort of a routine and do they all get antibiotics? And I'm talking about people with combat injury, do they all get antibiotics? Was there any sort of protocol, routine, that was used that was applied across the board?

A: They would get antibiotics if we had them during and after surgery, but there were times we didn't have the antibiotics. We used penicillin and streptomycin.

Q: That was it?

A: That was it. And we always didn't have penicillin.

Q: And no syphilis ports at that point?

A: No. From May, June, July of '65 until January and February of '66, about six months later, they were building the Navy Station Hospital at Da Nang, which was a first class medical facility. They had everything that you could

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<sup>11</sup> Corporal Robert E. O'Malley (3/3) and Lance Corporal Joe C. Paul (2/4) received the Medal of Honor for their actions during the operation. Paul's award was posthumous.

possibly want including their frozen blood program. I think they were quite successful in using it, but I don't think that that was their mainstay. I think the mainstay was fresh blood.

The hospital ship USS *Repose* arrived in February '66, the week that I left. We didn't have the backup of the Navy Station Hospital, or the Hospital Ship during the time I was there.

Q: How many beds did you have in your facility for holding people?

A: I probably had 100 cots. And we had one ward for post-op casualties.

Q: No ICU, of course.

A: That was the ICU.

Q: It was blood pressure cuffs and...

A: Yes, giving more blood and fluids and antibiotics. This was managed by Hospital Corpsmen.

Q: So your senior Corpsmen, you had chiefs who...

A: We had second and first-class Corpsmen managing the field hospital. They all did their job. I mean, it was just like

clockwork; you didn't have to tell a Corpsman what to do. They just did it. We had no discipline problems.

Q: They were too darn busy to get in trouble it sounds like.

A: There was no place to get in trouble.

Q: So Starlite went on for how many days?

A: Starlite went on, actually for five days, but 95% of it went on day one, it all happened day one.

Q: So you got there in May; Starlite went down in August, and you left in February. So what happened between August and February?

A: Well, by the time Starlite was over we had our routine pretty well established, so it was just a matter of taking casualties as they came in. We didn't have the number we had in Starlite. It was a fairly steady flow of casualties, and we never had to evacuate for primary surgical care after that. It was the only day we actually...

Q: You were frankly overwhelmed.

A: Yes. After that we were always able to take care of everything that came in. About two weeks after Starlite, they brought helicopter squadrons in next to us, with two large landing areas for the helicopter squadrons; they were

right next to us-within 100 feet, they took up the rest of the beach just north of us. They had mostly CH-34s and Hueys.

Q: These were tactical-these Marines were using these for...

A: For their recon, gunships, MEDEVACs, everything. I mentioned before how quiet it was when we moved up there; it was really quiet and it dark as pitch. You couldn't see or hear anything at night. When the helicopter squadrons came in they took up our perimeter. They had the new perimeter beyond them, they put Marines on their perimeter. They were going to make sure that everyone knew they were there. For the first three nights it sounded like the first day of deer season in Minnesota. It appears that it may have prevented sappers from trying to blow up their helicopters in the future.

Q: Lots of gun fire.

A: A lot of gun fire, but it quieted down. I think the unique part of all this was that we had to transition from a Collecting Clearing Company to a field hospital, with the Marines and the Corpsmen that we had and the Medical Service Corps Officer.

Q: Yes, there are no manuals. I mean, you basically wrote your own manuals as you were going along.

A: Yes, we wrote our own manuals so to speak.

Q: Was the situation where you could pick up the phone and talk to somebody in Da Nang?

A: No, not very easily. When I had to communicate with them I had to fly up to see them.

Q: They were north of you?

A: They were north. Initially it was by helicopter because we didn't have an airstrip. After that it was by C-123s or C-130s.

Q: How often did you get to get up there while you were there? How often did you need to get up there?

A: I was up there every month. They weren't coming down except on the first day of Operation Starlite when the Division Surgeon flew down.

Q: But you would go up there, I mean, was that medical headquarters?

A: That was the battalion headquarters for the field hospital. We were companies; they were the battalion.

Q: Got it. So you could go up there to talk about logistical issues or personnel issues.

A: Yes, that was what I was supposed to go up there for. There were no major problems. I took care of all the problems.

Q: But at some point, so initially you wrote the letter to your old boss back in Oakland to get supplies, but at some point did a medical logistical chain get set up with an infrastructure?

A: Yes, it eventually grew.

Q: Did most of that come out of Da Nang, or through Da Nang?

A: It had come through Da Nang. Shipments may have come from Okinawa, but to obtain something you had to go through Da Nang. I'm not criticizing them; it was just the logistics. Communication just wasn't very good at the time.

Q: Well, it was the mid-60s, late 60s.

A: I eventually was assigned a second anesthesiologist.

Q: Did you have to request him?

A: Yes, we requested him. Before I left I drew up plans for expansion of the facility with four operating rooms and I left the plans with them, I received a letter from a Corpsman about two or three months later, they had built

the four new ORs; they were very busy after I left, much busier.

Q: Who was your successor?

A: I was replaced by four orthopedic surgeons. One of them was an established hand surgeon in L.A. who came back onto active duty to go to Vietnam.

Q: A reservist?

A: I don't know for sure. His name was Ron Ashworth; he was with the primary hand group in L.A. The other two, Bob Leffert and Dick Braun were hand surgeons who had their fellowships, Bob Leffert became a professor at the Massachusetts General. Dick Braun went to San Diego to practice, was very successful, very well known, and very well written. And then there was a fourth orthopedic surgeon, but I don't think he was permanent; I think he was replaced by someone else. They improved upon what I had done.

Q: Built upon it. So, going back do you have any vignettes, patient vignettes, lessons learned from that experience, stories to tell in addition to the stories you've already told about establishing the hospital-individuals or people



you've worked with, or sort of a sense of the tenor of the times.

A: In a situation like this I think experience helps, and administratively experience helps. As far as what we were doing I think we did a good job taking care of casualties.

Q: So basically if they made it to you alive their chances of surviving were very good.

A: Yes, there were few casualties that died after we took care of him, and he was not a combat casualty. All the combat casualties we evacuated in two or three days, they were stable. The few we sent out early on were due to the fact that we just didn't have the set-up, for such things as burns. We did the primary surgery, but if the casualty was unstable there was no reason to keep them because they needed much more intensive care in a major facility. They went to Japan or Clark Air Force Base.

Q: They needed lung care, something like that?

A: Yes. There was a friend of mine, he was a captain in the engineering company, he had a tent a little ways away from mine on the beach, so I always used to go talk to him.

Q: Marine Corps captain.

A: He was a Marine Corps captain. About three months after I was there he ended up on my operating table, a bridge had blown up with an IED they had repaired the bridge and put it back together. He was standing on the riverbed not too far from the bridge when they drove a truck across it. They didn't know there was a second IED which went off. He, fortunately, had his helmet and flak jacket on. He was full of holes from head to foot one fragment broke his jaw. His flak jacket covered his abdomen and chest. He didn't have any visual problems, but every place else had fragment perforations. It took me three hours to debride him under local anesthesia.

Q: Is that right? You inject local into these holes?

A: Yes, into and around the wounds. We had our last three hours of conversation and he went on his way through the MEDEVAC route back to the U.S.

Q: So, you mentioned IEDs and this is interesting. We think of IEDs as being an innovation from Iraq, but the Vietnamese were using Improvised Explosive Devices as well? I don't remember hearing that term used in that time.

A: We didn't use that term, but that's what they were.

Q: So, I think you did mention earlier that half your patients were non-combat casualties and that was pretty much your experience your whole time?

A: Yes, fifty percent.

Q: And mostly infections, or were there vehicle accidents or truck accidents and people getting hit by vehicles and stuff like that?

A: A few vehicle accidents. Most were medical with a few psychiatric casualties.

Q: And you mentioned the psychiatrist.

A: Yes, we had a psychiatrist; he did an outstanding job.

Q: You never talked with him about how he did it?

A: No, I wanted to when I found out he ended up practicing at Oakland, but he passed away before I got a chance to talk to him.

When I left Vietnam in February of '66, I came back to the Naval Hospital, Oakland, because I was on TAD, so I was still on the staff. When I returned to Oakland, my chief of service gave me the amputee ward, the Amputee ward was supported by the Naval Prosthetics Research Lab at Oakland

Naval Hospital. We had approximately 25 amputees on the ward at any one time in various stages of reconstruction.

Q: So these were inpatients?

A: These were all inpatients.

Q: Mostly combat amputees?

A: They were all combat amputees. This was 1966, so this was the second year in Vietnam. With the Naval Prosthetics Research lab, we took care of the amputees on the West Coast, Army, Navy, and Marine Corps. I was put in charge with an orthopedic resident; basically it was doing the reconstructive work on their amputations.

Q: Because their amputations had been done, not necessarily in field hospitals, but overseas someplace, typically?

A: The amputations had been done prior to receiving them, they were done probably in the field hospitals. Some had probably been done in Japan or Guam, or Clark Air Force Base.

Q: So the Naval Hospital in the Philippines, you didn't get much cliental, any referrals to the Naval Hospital, or any referrals coming back through...

A: I don't know how many actually came back from the Air Force facility in the Philippines. Some came from Clark Air Force Base. Guam had a very large number of combat casualties at their facility, and Japan the same way. We would reconstruct their amputations as needed and one of the things that helped us a great deal with amputees was the mesh skin graft. The split thickness is meshed so it looks like a piece of lace. Then you lay the meshed skin on the open wound. You could put it over infected wounds, the graft would take during the time that exudate was draining through the mesh. When the mesh graft healed, the tissue edema decreased and the tissue edema decreased and would contract.

Q: So that was an innovation at the time?

A: The use of the mesh skin graft was an innovation that was started at Naval Hospital, Oakland. The concept was presented at the first military medical conference during Vietnam in '66 and was used through all the military hospitals.

I was on the amputee service for approximately one year. The Naval Hospital, Oakland, at that time had about 300 patients on the orthopedic service. Dana Goldthwaite, Chief of the Orthopedic Service, decided he wanted to

retire. He asked if I'd take the service. By that time I was a commander, when I took charge of the orthopedic department.

Q: And you had a residency program, so you were actually running a residency?

A: Yes, we had three general orthopedic residents per year for a total of nine residents. The first thing I did was to start a hand service. I went to San Francisco to spend time with Lot Howard, a well-known hand surgeon. He was Sterling Bunnell's second partner. Sterling Bunnell started the specialty of hand surgery after World War II. Our residents would rotate through the office of Lot Howard in San Francisco for three months. I established the hand service so that when the residents came back to Naval Hospital Oakland they could spend six months on the hand service taking care of the hand injuries. I had the orthopedic service for two and a half years-the result of that war there were a lot of orthopedics surgeon residents who went into hand surgery, and one of them who was a first year resident when I left, he eventually became the president of the American Society for Hand Surgery.

Q: So this was the first hand service in the Navy?

A: That I don't know. I know the Army had one at Brooke Army Hospital in Texas, and they may have had two, I'm not sure. Whether there was another one in the Navy at the time or not, was Chief of Orthopedics for two and a half years. I separated from active naval service in 1970 when I completed my obligated time.

Q: And the rest, as they say, is history I guess.

A: Yes.

Q: So you were in the Navy for a total of...

A: I was on active duty in the Navy for 13 years.

Q: And you stayed in the Reserves?

A: I then completed eight years of active reserve time.

Q: And retired after how many years?

A: I had four years in the National Guard starting in high school and college. So that added on to the eight years in the naval reserve for a total of 12 years reserve time.

Q: And retired as an O6?

A: Right.

Q: So where did you drill when you were in the Reserves?

A: I was an orthopedic consultant to the Naval Weapons Station in Concord, CA for about six years.

Q: Wow that sounds like a really valuable service.

A: The last two years in the reserve I did my reserve time at Alameda, CA. It was an administrative decision.

Q: Where'd you do your two weeks every year?

A: Usually at Naval Hospital, Oakland. I didn't do a full two weeks every year.

Q: That's the end of the interview, as far as I'm concerned, unless you've got some philosophical lessons learned? You've already mentioned the fact that experience says it all, and it seems interesting that we have to relearn lessons that we've learned before. I mean, you experienced it at the blood bank and the fact that you had to basically start your own blood bank, and that the blood supply, or the system, was simply inadequate when you started up.

A: Starting the blood bank at the field hospital was essential to the survival of the wounded casualties. What else can you do?

Q: For survival, you've got to resuscitate these guys who have lost blood.



A: To me everything we did was very logical, it had to be done.

Q: Were you ever scared?

A: I had a moment on that first morning of Operation Starlite that I suddenly realized we had more casualties than we could take care of. We had to evacuate those who could survive the travel to Da Nang and eventually for some to Clark Air Force Base in the Philippines.

Q: So how did that evolve? At some point sort of that oh my god unit happens. I mean, do you pick up the phone and say, "We got to get a bunch of helicopters up here?" How did that evolve?

A: It was kind of interesting. The Division Surgeon come down to Chu Lai that morning because he knew there was a major operation. He knew that there was a heavy conflict-or maybe it was after he found out what was happening, I don't know, but he came down that morning.

Q: When things were already busy?

A: Right, when we were taking casualties and we were up to our eyeballs with casualties. He come down that morning by helicopter. He was a radiologist at Naval Hospital, Chelsea, when I was an orthopedic resident. His office was

next to our clinic. So, we knew each other very well. The decision was made just like that to evacuate casualties. That was it.

Q: So all he had to do was pick up his Marine Corps phone and say, "I need, blah, blah, blah," and that was it. They just took care of it?

A: Yes. I'm sure that his presence made a tremendous difference in how rapidly the evacuation was started.

Q: I'm sure. He's the eyeballs right there. He's looking going, "Yes, right, these guys need help."

A: Yes, it was an immediate decision, and it happened within minutes. The treatment concept with the immediate evacuation of casualties who could travel with surgical treatment elsewhere.

Q: So, the casualties started arriving at what time?

A: Seven o'clock, 8:00 in the morning.

Q: And when did you realize that this was a big deal?

A: By 9:00.

Q: And when did things sort of tail off to the point where you could actually breathe again?

A: I do not remember. Basically, it lasted all day. I just knew what I had to do and did it.

Q: Because you were operating, but you were also administering.

A: I was triaging that day. The general surgeons were taking care of the guys that couldn't travel so they could survive.

Q: So in reality, once the decision was made to start evacuating, that made your job easier in a sense because at least you knew that once you said, "This guy goes," that he was going to go and you didn't have to think about-other than making sure he's not bleeding out and he's got the IVs and the blood and all that stuff.

A: I just had to make sure he was stable and could leave.

Q: And you had a team of Corpsmen who were helping with that kind of stuff.

A: They did what they had to do. They got the IVs started, they started the blood, and I just had to make sure that each one got the blood they needed.

Q: And all this with blood pressures and clinical observation.

A: This was all basically clinical.

Q: And assessing wounds. And so when you're triaging, you had to do, kind of, head to toe evaluation, sort of the standard thing.

A: It as so automatic by that time. It didn't require a thought process.

Q: When you say automatic, because you'd been doing it for awhile anyway, and then when this day happened..

A: Right, you'd been doing it all the time, and this day was just more so, so you did what you had to do. It doesn't sound very academic.

Q: No, but it's practical. It's taking care of business and saving lives.

A: Yes.

Q: Alright, any other thoughts? Do you want to do the DVD?

A: Yeah, I'll show you so you have at least have an idea what the place was like.

Q: Yes, maybe you can narrate the DVD because we'll have the DVD and I'll send that back to the Bureau, and that way they'll have your narrative.